PRINTED: 06/29/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G174 | A. BUILDING _____ B. WING _____ | 06/26/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SYMBRAL | 4422 20TH STREET, NE WASHINGTON, DC 20011 |

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| W 000 | INITIAL COMMENTS<br><br>Surveyor: 19076<br><br>A recertification survey was conducted from June 25, 2007 thru June 26, 2007. The survey was initiated using the fundamental survey process; however, as a result of the review of unusual incident reports and interviews, it was decided to extend the survey process in the area of Client Protections. A random sample of three clients was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home and three day programs, and interviews with clients, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The survey findings determined that the facility failed to substantially comply with the Condition of Participation in Client Protection. | W 000 | | |
| W 104 | 483.410(a)(1) GOVERNING BODY<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas:<br><br>The finding includes:<br><br>The governing body failed to ensure the | W 104 | | |

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HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr Yvonne Mohammed — TITLE: CEO — (X6) DATE: 7/24/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 104 | Continued From page 1<br>maintenance of the facility's environment, as evidenced by:<br><br>a. Peeling paint around the exterior front window frame;<br><br>b. Peeling paint around the exterior front panel next to the front door of the facility;<br><br>c. Broken chair in the backyard;<br><br>d. Peeling paint on the exterior front panels next to the gutters on the front of the facility; and<br><br>e. Rust on fence posts in the backyard. | W 104 | Peeling paint around the exterior front window frames, panel next to the front door and exterior front panels next to the gutters on the front of the facility has been scraped and repainted.<br><br>The broken chair in the backyard has been discarded.<br><br>See both A and B.<br><br>The rusted areas on the backyard fence has been removed and replaced with new fencing. | 7/31/07-Ongoing |
| W 120 | 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES<br><br>The facility must assure that outside services meet the needs of each client.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of three clients in the sample. (Client #1 )<br><br>The finding includes:<br><br>Observation during the lunch mealtime at the day program on June 25, 2007 at approximately 12:15 PM revealed that Client #1 was served a pureed diet in a sectioned paper plate. Further observation revealed that Client #1 was eating at a very rapid pace and was verbally prompted to | W 120 | The house manager will complete a routine environmental check and forward all requests for repairs to maintenance.<br><br>A current mealtime protocol has been forwarded to Client # 1's day program. The QMRP met with day program staff to discuss the nutritional needs of Client #1. QMRP will ensure that Client # 1 is effectively monitored in his day program by visiting routinely and providing ongoing training as necessary regarding Client # 1's support needs. | 7/16/07 - Ongoing |

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| W 120 | Continued From page 2<br>slow down his eating pace. The client complied and than suddenly got out of his chair holding his plate while continuing to consume the food. The staff physically/verbally had to stop the client from eating and return to the table for the remainder of his meal. In an interview with the day program staff, on June 25, 2007 at approximately 12:25 PM, it was acknowledged that Client #1 was on a ground diet. Further interview revealed that Client #1 did have a current mealtime protocol dated February 5, 2007 which indicated that the client was on a ground diet. Review of the Nutrition Assessment, dated January 24, 2007, on June 26, 2007 at approximately 2:30 PM revealed that "based on the December 10, 2006, swallowing study Client #1 was recommended an 1800 calorie, low fat, low cholesterol, no added salt ground diet moistened with gravy diet". There was no evidence Client #1 was served a ground diet as recommended by the nutritionist in the day program. | W 120 | | |
| W 122 | 483.420 CLIENT PROTECTIONS<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on interview and record review, the facility failed to effectively monitor each client's day program to assure that the dietary needs were met for Client #1[Refer to W120]; the facility failed to ensure that systems had been developed and implemented to establish and implement policies that ensure each client's health and safety [Refer to W149]; failed to ensure the immediate | W 122 | Reference responses to W120, W149, W153, W154, W192 and W263. | |

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| W 122 | Continued From page 3<br>notification of the State officials of injuries of unknown origin and emergency medical services [Refer to W153]; and failed to thoroughly investigate injuries of unknown origin [Refer to W154] ; failed to ensure effectively trained staff to implement emergency measures [Refer to W192]; failed to ensure that restrictive programs were used only with written consents [Refer to W263].<br><br>The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being. | W 122 | | |
| W 124 | 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br>Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of two clients in the sample. (Client #3 )<br><br>The finding includes:<br><br>Observation of the evening medication | W 124 | Assessment for legal guardianship will be completed for client #3 and pursuance for guardianship will occur based on the assessed needs of Clients #3.<br><br>Additionally, QMRP will continue to ensure that family members are fully knowledgeable and understand the rights of the clients. QMRP will also ensure documentation of information regarding all efforts to involve family members in the decision making process as well as ongoing measures (i.e., Human Rights Committee Reviews to discuss risk –vs- benefits) to ensure protection of their rights.<br><br>QMRP will continue to pursue securing legal advocacy, as well as, guardianship resources through the quality trust, courts and other applicable services, based on the individual needs for each client. Documentation of these ongoing efforts will be maintained in the client records.<br><br>Client #3's psychotropic medication regimen will continue to be evaluated monthly by the psychiatrist and psychiatric evaluations reviewed and updated per individual assessment and need | 7/31/07-Ongoing |

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| W 124 | Continued From page 4<br>administration on June 25, 2007 at approximately 5:55 PM, revealed Client #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:05 PM revealed that these medications along with Haldol Deconoate 100 mg IM every two weeks was prescribed for behavior management. Review of the Client #3' s physicians orders dated June 1, 2007 on June 26, 2007 at approximately 3:50 PM revealed that Risperdal 1.5 mg and Trazadone 150 mg by mouth twice a day and Haldol Deconoate 100 mg IM every two weeks was incorporated in a Behavior Support Plan (BSP) dated February 21, 2007, to address behaviors associated with elopement and physical aggression. Interview with the House Manager on June 26, 2007 at approximately 3:55 PM revealed that Client #3 did not have a legal guardian or surrogate decision maker. The review of Client #3's Psychological Assessment dated February 4, 2007 on June 26, 2007 at approximately 4:50 PM indicated that he does not evidence the capacity to make independent decisions on he behalf regarding his habilitation planning, placement, treatment, financial and medical matters and can not give informed consent. There was no documented evidence that the facility informed Client #3 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. | W 124 | | |
| W 149 | 483.420(d)(1) STAFF TREATMENT OF CLIENTS<br><br>The facility must develop and implement written | W 149 | | |

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| W 149 | Continued From page 5<br>policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on staff interview and record review, the facility failed to develop and implement its established policies to ensure the health and safety for six of the six clients in the sample. (Client #1,#2,#3,#4,#5 and #6)<br><br>The finding includes:<br><br>1. Cross refer to W153. The facility failed to develop a policy on reporting incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on June 25, 2007 at approximately 4:15PM revealed that the facility did not report incidents that posed a risk to client health or safety to the Department of Health (DOH). Review of the facility's "Incident Management Policy" on June 25, 2007 at approximately 4:25PM revealed that allegations of abuse, neglect and mistreatment are to be reported no later than eight hours to the DOH. There was no documented evidenced that the facility reported incidents that posed a risk to client health or safety to the DOH.<br><br>2. The facility failed to implement their policy on reporting incidents of neglect to governmental agencies, as required by DC regulation (22 | W 149 | The Program Director will revise and clarify the agency's Policies and Procedures to further address identification, classification and handling of incidents following regulatory guidelines. Incidents will be managed in accordance with DC regulation 22 DCMR Chapter 35 Section 3519.10. Staff will be re-trained on the incident reporting procedures. The incident alleging abuse and neglect for Client # 3 will be forwarded to DOH. | 7/31/07 |

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| W 149 | Continued From page 6<br>DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Interview with the House Manager on June 25, 2007 at approximately 4:20 PM revealed that the facility did report allegations of neglect no later than eight hours to the DOH. Review of an unusual incident report dated May 25, 2007 on June 25, 2007 at approximately 10:19AM revealed that Client #3 who had one to one staffing eloped from the facility on that date. There was no documented evidenced that the DOH was notified of the incident.<br><br>3. The facility failed to implement their policy on reporting incidents of abuse to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Review of an unusual incident report dated March 2, 2007 on June 25, 2007 at approximately 10:19 AM revealed that Client #3 was pushed by Direct Care Staff #1 after the client spat on the direct care staff. Interview with the House Manager on June 25, 2007 at approximately 10:20 AM revealed that Direct Care Staff #1 was immediately removed from duty and subsequently terminated her employment from the facility. Review of the facility's "Incident Management Policy" on June 25, 2007 at approximately 4:25PM revealed that allegations of abuse, neglect and mistreatment are to be reported no later than eight hours to the DOH. There was no documented evidence that this incident had been reported to governmental agencies as required, | W 149 | See page 6 | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS | W 153 | | |

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| W 153 | Continued From page 7<br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10).<br><br>The findings include:<br><br>1. Review of an unusual incident report dated June 20, 2007 on June 25, 2007 at approximately 10:15 AM revealed that Client #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:16 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>2. Review of an unusual incident report dated May 25, 2007 on June 26, 2007 at approximately 10:17AM revealed that Client #3 who had one to one staffing eloped from the facility on that date. Interview with the House Manager on June 25, 2007 at approximately 4:20 PM revealed that Direct Care Staff #2 was placed on administrative leave. Review of a progress note dated May 25, | W 153 | Reference responses to W149<br><br>Additionally, QMRP will ensure that all incidents reports are generated to all pertinent parties and investigated according to policy and procedure. | 7/31/07 |

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| W 153 | Continued From page 8<br>2007 on June 26, 2007 at approximately 3:00PM revealed that when Client #3 returned to the facility on May 25, 2007, his left knee and ankle was swollen. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>[Note: Review of a progress note dated May 25, 2007 on June 26, 2007 at approximately 3:00PM revealed that when Client #3 returned to the facility on May 25, 2007, with a swollen left knee. Review of a radiology report of the right/left knees dated June 4, 2007 on June 26, 2007 at approximately revealed that the Client #3 had not sustained any fractures to the knees]<br><br>3. Review of an unusual incident report dated May 30, 2007 on June 26, 2007 at approximately 5:22 PM revealed that while at the day program Client #1 was discovered to have a "purple bruise on his left pinky and ring finger". Further review revealed that Client #1 was sent to the emerency room and was treated and released with a finger splint. Interview with the House Manager on June 25, 2007 at approximately 5:23 PM revealed that the incident had been forwarded to the facility's incident management coordinator. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>4. Review of an unusual incident report dated May 1, 2007 on June 25, 2007 at approximately 10:17 AM revealed that Client #6 sustained cuts on the fingers of the left hand. Interview with the House Manager on June 25, 2007 at approximately 10:18 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no | W 153 | See page 8 | |

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| W 153 | Continued From page 9<br>documented evidence that this incident had been reported to governmental agencies as required.<br><br>5. Review of an unusual incident report dated April 24, 2007 on June 25, 2007 at approximately 10:19 AM revealed that Client #6 fell half-way down some staires and than hit his left hand on the doors plate glass which broke and he was sent to the emerency room. Further review revealed that the client was treated and released without sutures. Interview with the House Manager on June 25, 2007 at approximately 10:20 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>6. Review of an unusual incident report dated March 2, 2007 on June 25, 2007 at approximately 10:22 AM revealed that Client #3 was pushed by Direct Care Staff #1 after the client spit on the direct care staff. Interview with the House Manager on June 25, 2007 at approximately 10:23 AM revealed that Direct Care Staff #1 was immediately removed from duty and subsequently terminated her employment from the facility. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>7. Review of an unusual incident report dated June 29, 2006 on June 25, 2007 at approximately 10:24 AM revealed that Client #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:25 AM revealed she was aware of the incident and that the facility's incident | W 153 | See page 8 | |

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| W 153 | Continued From page 10<br>manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>8. Review of an unusual incident report dated August 23, 2006 on June 25, 2007 at approximately 10:26 AM revealed that Client #2 fell and sustained a laceration on his forehead and was transported via 911 to the emerency room and treated with nine sutures and released. Interview with the House Manager on June 25, 2007 at approximately 10:27 AM revealed she was aware of the incident and that the facility's incident management coordinator had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>9. Review of an unusual incident report dated May 13, 2006 on June 25, 2007 at approximately 10:28AM revealed that Client #4 had eloped from the facilty on that date at 2:00PM and was found by the D.C. Metropolitan Police. Interview with the House Manager on June 25, 2007 at approximately 10:30 AM revealed that she was aware of the incident and that the facility's incident managment coordinator had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required. | W 153 | See page 8 | |
| W 154 | 483.420(d)(3) STAFF TREATMENT OF CLIENTS<br><br>The facility must have evidence that all alleged violations are thoroughly investigated. | W 154 | | |

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| W 154 | Continued From page 11<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on interview and review of medical records the facility failed to document the provision of thorough investigations of injuries of unknown origin for the two of three clients in the sample. (Client #2 and Client # 6)<br><br>The finding includes:<br><br>1. Review of an unusual incident report dated June 20, 2007 on June 25, 2007 at approximately 10:15 AM revealed that Client #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:16 AM revealed she was aware that the incident had not been investigated. There was no evidence that this incident of unknown origin was investigated.<br><br>2. Review of an unusual incident report dated May 1, 2007 on June 25, 2007 at approximately 10:17 AM revealed that Client #6 sustained cuts on the fingers of the left hand. Interview with the House Manager on June 25, 2007 at approximately 10:18 AM revealed she was aware that the incident had not been investigated. There was no evidence that this incident of unknown origin was investigated. | W 154 | Investigation of the incident involving Client # 2 from the unusual incident report dated 6/20/07 will be conducted.<br><br>Investigation of the incident involving Client # 6 from the unusual incident report dated 5/1/07 will be conducted.<br><br>The investigation/s and all supporting documentation will be forwarded per policy and procedure. | 7/31/07 |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. | W 159 | | |

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| W 159 | Continued From page 12<br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br>Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for six of six clients in the facility. (Client #1,#2,#3,#4,#5 and #6)<br><br>The findings include:<br><br>1. The QMRP failed to coordinate services with Client #1's day program to ensure that he was served a ground diet as evidenced by:<br><br>Observation during the lunch mealtime at the day program on June 25, 2007 at approximately 12:15 PM revealed that Client #1 was served a pureed diet in a sectioned paper plate. Further observation revealed that Client #1 was eating at a very rapid pace and was verbally prompted to slow down his eating pace. The client complied and than suddenly got out of his chair holding his plate while continuing to consume the food. The staff physically/verbally had to stop the client from eating and return to the table for the remainder of his meal. In an interview with the day program staff on June 25, 2007 at approximately 12:25 PM it was acknowledged that Client #1 was on a ground diet. Further interview revealed that Client #1 did have a current mealtime protocol dated February 5, 2007 which indicated that the client was on a ground diet. Review of the Nutrition Assessment dated January 24, 2007 on June 28, 2007 at approximately 2:30 PM revealed that "based on the December 10, 2006, swallowing study Client #1 was recommended an 1800 calorie, low fat, low cholesterol ,no added salt ground diet moistened with gravy diet". There was no evidence Client #1 was served a ground | W 159 | Cross reference response to W120. | 7/31/07-Ongoing |

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| W 159 | Continued From page 13<br>diet as recommended by the nutritionist in the day program.<br><br>2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for six of six clients in the facility as evidenced by:<br><br>Interview with the House Manager on June 26, 2007 at approximately 4:58 PM revealed that all staff was not trained in CPR. Record review on June 26, 2007 at approximately 4:59 PM revealed that two out of eleven staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.<br><br>3. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for six of six clients in the facility as evidenced by:<br><br>In an interview with the House Manager on June 26, 2007 at approximately 4:56 PM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 4:57 PM revealed that three out of eleven staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. | W 159 | All staff lacking training in CPR will receive training.<br><br>All staff lacking training in First Aid will receive training.<br><br>The QMRP and House Manager will review staff training needs on a monthly basis and register staff for training within 60-days of the expiration dates of current training. A schedule of upcoming training will continue to be posted in each facility. | 7/31/07-Ongoing<br><br>7/31/07-Ongoing<br><br>7/31/07-Ongoing |
| W 170 | 483.430(b)(5) PROFESSIONAL PROGRAM SERVICES<br><br>Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. | W 170 | | |

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| W 170 | Continued From page 14<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on staff interview and record review, the facility failed to ensure that all professionals are licensed and/or certified in accordance with the District of Columbia Laws.<br><br>The finding include:<br><br>The review of personnel records on June 26, 2007, at approximately 12:45PM indicated that the professional licenses for the Primary Care Physician and Social Worker were not available for review. There was no evidence that the Primary Care Physician and Social Worker were currently licensed in accordance with the Health Occupation Revision Act (HORA), Title 3 Chapter 12, Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.") | W 170 | The professional licenses for the Social Worker and Primary Care Physician have been obtained. The Program Director will ensure that the professional licenses of all consultants are in compliance and maintained on file in a conspicuous manner per HORA guidelines. | 7/16/07 |
| W 189 | 483.430(e)(1) STAFF TRAINING PROGRAM<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and | W 189 | | |

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| W 189 | Continued From page 15<br>competently.<br><br>The findings include:<br><br>1. Cross Refer to W153. The facility failed to ensure that staff had received effective training on reporting unusal incidents to the Department of Health.<br><br>2. Cross Refer to W154. The facility failed to ensure that staff had received effective training on investigating unusual incidents.<br><br>3. Cross Refer to W192. The facility staff failed to ensure that staff had received effective training in implementing emerency measures .<br><br>4. Cross Refer to W440. The facility failed to ensure that staff had received effective training on documenting evacuation drills quarterly on all shifts.<br><br>5. Cross Refer to W441. The facility failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions. | W 189 | Reference response to W153. Cross reference W149.<br><br>Reference response to W154.<br><br>Reference response to W159 #2-3<br><br>Reference response to W440.<br><br>Reference response to W441. | 7/31/07-Ong oing |
| W 192 | 483.430(e)(2) STAFF TRAINING PROGRAM<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of six | W 192 | | |

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| W 192 | Continued From page 16<br>clients in the facility. (Clients #1, #2, #3, #4, 5 and 6 )<br><br>The findings include:<br><br>1. Interview with the House Manager on June 26, 2007 at approximately 4:58 PM revealed that all staff was not trained in CPR. Record review on June 26, 2007 at approximately 4:59 PM revealed that two out of eleven staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.<br><br>2. Interview with the House Manager on June 25, 2007 at approximately 4:56 PM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 4:57 PM revealed that three out of eleven staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. | W 192 | Reference response to W159 #1.<br><br>Reference response to W159 #2. | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was | W 263 | | |

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| W 263 | Continued From page 17<br>conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of two clients in the sample (Client #3).<br><br>The finding includes:<br><br>Cross Refer to W124. The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #3's Behavior Support Plan (BSP) as evidenced by:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 5:55 PM, revealed Client #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:05 PM revealed that the medication was prescribed for behavior management. Review of the Client #3' s physicians orders dated June 1, 2007 on June 26, 2007 at approximately 3:50 PM revealed that Risperdal 1.5 mg and Trazadone 150 mg by mouth twice a day and Haldol Decanoate 100 mg IM every two weeks was incorporated in a Behavior Support Plan (BSP). Review of Client #3's Psychological Assessment dated February 4, 2007 on June 26, 2007 at approximately 4:50 PM indicated that he does not evidence the capacity to make independent decisions on his behalf regarding his habilitation planning, placement, treatment, financial and medical matters and can not give informed consent. Review of the BSP dated February 21, 2007 on June 26, 2007 at approximately 4:55PM revealed that Client #3 has targeted behaviors that include elopement and physical aggression. Further review revealed a recommendation for a manuel restraint procedure by trained staff to control aggressive | W 263 | Reference response to W124. | |

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| W 263 | Continued From page 18<br>behavior. Interview with the House Manager and record review on June 26, 2007 at approximately 5:00 PM revealed that staff has never used the manuel restraint proceedure on Client #3. Further interview revealed that Client #3 also has one to one staffing support 24 hours a day. The Human Rights Committee (HRC) minutes were requested, however at the time of the survey the facility failed to provide evidence of the HRC minutes. There was no documented evidence that the facility had obtained written informed consent for the use of Client #3's BSP. | W 263 | | |
| W 322 | 483.460(a)(3) PHYSICIAN SERVICES<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br>Based on observation, staff interview, and record review failed to provide preventive and general care for two of three clients in the sample. (Client #1and Client #3)<br><br>The findings include:<br><br>1. The facility's medical services failed to ensure that Client #1's psychotropic reviews were in the medical record as evidenced by:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 6:15 PM, revealed Client #1 received Loxapine 50mg and Depakote 750 mg by mouth. Interview with the nursing staff on June 26, 2007 at approximately 6:16 PM revealed that the medication was prescribed for behavior | W 322 | The Designated/Medication Nurse will ensure that Client #3 is encouraged. to participate in his medication administration to the extent of which assessed capable. | 7/16/07 |

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| W 322 | Continued From page 19<br>management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis I diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that there were no psychotropic reviews for April and May 2007. In an interview with the House Manager on June 26, 2007 at approximately 1:30 PM it was acknowledged that Client #1 did not have psychotropic reviews for April and May 2007<br><br>2. The facility's medical services failed to ensure that Client #3's psychotropic reviews were in the medical record as evidenced by:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 5:55 PM, revealed Client #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:05 PM revealed that the medication was prescribed for behavior management. Review of Client #3's Psychiatric Assessment dated February 8, 2007 on June 26, 2007 at approximately 3:30 PM revealed that Client #3 has an Axis I diagnosis of Chronic Undifferentiated Schizophrenia. Review of Client #3's medical record on June 26, 2007 at approximately 3:35 PM revealed that there were no psychotropic reviews for April and May 2007. In an interview with the House Manager on June 26, 2007 at approximately 4:40 PM it was acknowledged that Client #3 did not have psychotropic reviews for April and May 2007.<br><br>3. Cross refer to W331.1. The facility's nursing services failed to ensure that the results of Client #3's EEG studies were obtained. | W 322 | Nurse has followed up with the psychiatrist to obtain the reviews from the psychotropic meetings held in April and May 2007. Nurse will ensure that the Psychotropic review forms are obtained and filed in the clients records within 24 hours following the medication review.<br><br>The EEG results have been obtained and filed for Client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of laboratory studies are obtained and filed in the client records. | 7/16/07<br><br>7/16/07 |

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| W 322 | Continued From page 20<br><br>4. Cross refer to W371.2. The facility's nursing services failed to ensure that Client #3 participated in a self-medication program. | W 322 | | |
| W 331 | 483.460(c) NURSING SERVICES<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of three clients in the sample. (Client # 3)<br><br>The findings include:<br><br>1. The facility's nursing services failed to ensure that the results of Client #3's EEG studies were obtained as evidenced by:<br><br>Review of an EEG consult dated September 26, 2006 on June 20, 2007 at approximately 4:05PM revealed that Client #3 had an EEG performed on that date and that the facility could call for the results. Interview with LPN on June 26, 2007 at approximately 4:08 PM revealed Client #3's EEG results were not obtained. There was no documented evidence that the results of the EEG results were obtained by the facility. | W 331 | Cross reference response to W322 #3. | 7/16/07 |
| W 371 | 2. Cross refer to W371.2. The facility's nursing services failed to ensure that Client #3 participated in a self-medication program.<br>483.460(k)(4) DRUG ADMINISTRATION | W 371 | Cross reference response to W322 # 1.<br><br>See page 22 | 7/16/07 |

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| W 371 | Continued From page 21<br>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observations, staff interview and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for one of three clients in the sample. (Client #3)<br><br>The finding includes:<br><br>During the observation of the evening medication pass, on June 25, 2007 at approximately 5:55 PM, Client #3 was administered Risperdal 1.5 mg and Trazadone 150 mg by mouth by the LPN. Client #3 was observed to bring a cup of water to the table when he came to receive his medication. Further observation revealed that Client #3 was able to independently hold his medicationcup and cup of water and consume thre contents with-out spillage. Client #3 was observed to pour Lactolose 30 ml in a cup, mix water in the cup and stir the contents with a spoon before consuming the medication. Interview with the LPN on June 25, 2007 at approximately 5:57PM revealed that Client #3 had a self-medication assessment but did not have a self-medication program. Review of the self-medication assessment dated February 2, 2007 on June 26, 2007 at approximately 4:11PM indicated that Client # 3 was recommended " | W 371 | Cross reference response to W322 #1 | |

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| W 371 | Continued From page 22<br>monitor level of participation medication administration in the next 90 days. Review of the Individual Support Plan (ISP) dated February 2, 2007 recommended that Client #3 "learn self-medication". There was no evidence that the client was given the opportunity to participate in a self- medication program. | W 371 | | |
| W 440 | 483.470(i)(1) EVACUATION DRILLS<br><br>The facility must hold evacuation drills at least quarterly for each shift of personnel.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on record review, the facility failed to hold evacuation drills quarterly on all shifts.<br><br>The finding includes:<br><br>Interview with the House Manger on December 21, 2006 revealed that the staff schedules for the weekday and weekend shifts are as follows:<br><br>Weekday Shifts are as follows:<br><br>Day shift: 9:00 AM [Clients go to day program]<br>Evening shift: 2:30 PM to 11:00 PM<br>Night shift: 11:00 PM to 9:00 AM<br><br>Weekend Shifts are as follows:<br><br>Day shift: 9:00 AM to 9:00 PM<br>Overnight: 9:00 PM to 9:00 AM<br><br>Review of the available fire drill records dated from March 6, 2006, to June 4, 2007 on June 25, 2007 at approximately 9:45 AM revealed that fire | W 440 | The QMRP and House Manager will review the fire drill records at least bi-weekly and monitor the implementation and documentation of fire drills to ensure that fire drills are conducted on a quarterly basis for each shift under using different exits and under varied conditions. | 7/16/07-Ongoing |

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| W 440 | Continued From page 23<br>drills were not conducted on the day and night shift during the second quarter. Further review revealed that fire drills were not conducted on the night shift during the third quarter and fire drills were not conducted on the day shift during the fourth quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly. | W 440 | | |
| W 441 | 483.470(i)(1) EVACUATION DRILLS<br><br>The facility must hold evacuation drills under varied conditions.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 19076<br>Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions.<br><br>The finding includes:<br><br>On June 25, 2007 at approximately 9:45AM review of fire drill records and interview with the House Manager revealed that during the past year, staff had not practiced exiting through all four egresess of the facility. Most fire drills were conducted via the front and side exits. There was no evidence that evacuation drills were being held under varied conditions. | W 441 | Reference response to W440<br><br>Additionally the QMRP/House Manager will ensure that staff receives in-service training on fire drills that will result in conducting drills at varied weather conditions. | |

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| R 000 | INITIAL COMMENTS<br><br>Surveyor: 19076<br><br>Based on interview and record review, the facility failed to ensure that all staff had police clearances on file.<br><br>The finding includes:<br><br>Review of eleven personnel records on June 26, 2007 at approximately 4:40 PM revealed no documented evidence of a police clearance for two staff members. Staff ([redacted] and [redacted]) | R 000 | Police clearances have been obtained for staff [redacted] and [redacted] | 7/12/07 |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| I 000 | INITIAL COMMENTS<br><br>Surveyor: 19076<br>A licensure survey was conducted from June 25, 2007 thru June 26, 2007. A random sample of three residents was selected from a resident population of six males with various disabilities. The survey findings were based on observations in the group home and three day programs, interviews with residents, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. | I 000 | | |
| I 001 | 3500.1 GENERAL PROVISIONS<br><br>Each group home for mentally retarded persons (GHMRP) shall comply with the general provisions stated in chapters 13 through 17 of Title 22 of the District of Columbia Municipal Regulations (DCMR).<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas:<br><br>The finding includes:<br><br>The governing body failed to ensure the maintenance of the facility's environment, as evidenced by:<br><br>a. Peeling paint around the exterior front window frame;<br><br>b. Peeling paint around the exterior front panel | I 001 | Peeling paint around the exterior front window frames, panel next to the front door and exterior front panels next to the gutters on the front of the facility has been scraped and repainted. | 7/16/07 |

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| I 001 | Continued From page 1<br>next to the front door of the facility;<br><br>c. Broken chair in the backyard;<br><br>d. Peeling paint on the exterior front panels next to the gutters on the front of the facility; and<br><br>e. Rust on fence posts in the backyard. | I 001 | The broken chair in the backyard has been discarded.<br><br>See page 1<br><br>The rusted areas on the backyard fence has been removed and replaced with new fencing. | 7/16/07<br><br>7/31/07-Ongoing |
| I 041 | 3502.2(a) MEAL SERVICE / DINING AREAS<br><br>Modified diets shall be as follows:<br><br>(a) Prescribed in the resident ' s Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident ' s record;<br><br>This Statute Is not met as evidenced by:<br>Surveyor: 19076<br><br>Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of three residents in the sample. (Resident #1 )<br><br>The finding includes:<br><br>Observation during the lunch mealtime at the day program on June 25, 2007 at approximately 12:15 PM revealed that Resident #1 was served a pureed diet in a sectioned paper plate. Further observation revealed that Resident #1 was eating at a very rapid pace and was verbally prompted to slow down his eating pace. The client complied and than suddenly got out of his chair holding his plate while continuing to consume the food. The staff physically/verbally had to stop the client from eating and return to the table for the remainer of | I 041 | The house manager will complete a routine environmental check and forward all requests for repairs to maintenance.<br><br>A current mealtime protocol has been forwarded to Client # 1's day program. The QMRP met with day program staff to discuss the nutritional needs of Client #1. QMRP will ensure that Client # 1 is effectively monitored in his day program by visiting routinely and providing ongoing training as necessary regarding Client # 1's support needs. | 7/16/07 - Ongoing |

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| I 041 | Continued From page 2<br>his meal. In an interview with the day program staff on June 25, 2007 at approximately 12:25 PM it was acknowledged that Resident #1 was on a ground diet. Further interview revealed that Resident #1 did have a current mealtime protocol dated February 5, 2007 which indicated that the client was on a ground diet. Review of the Nutrition Assessment dated January 24, 2007 on June 26, 2007 at approximately 2:30 PM revealed that "based on the December 10, 2006, swallowing study Resident #1 was recommended an 1800 calorie, low fat, low cholesterol ,no added salt ground diet moistened with gravy diet". There was no evidence Resident #1 was served a ground diet as recommended by the nutritionist in the day program. | I 041 | | |
| I 135 | 3505.5 FIRE SAFETY<br><br>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on record review, the facility failed to hold evacuation drills quarterly on all shifts.<br><br>The finding includes:<br><br>Interview with the House Manger on December 21, 2006 revealed that the staff schedules for the weekday and weekend shifts are as follows:<br><br>Weekday Shifts are as follows:<br><br>Day shift: 9:00 AM [Clients go to day program]<br>Evening shift: 2:30 PM to 11:00 PM<br>Night shift: 11:00 PM to 9:00 AM | I 135 | The QMRP and House Manager will review the fire drill records at least bi-weekly and monitor the implementation and documentation of fire drills to ensure that fire drills are conducted on a quarterly basis for each shift under using different exits and under varied conditions. | 7/16/07-Ongoing |

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| I 135 | Continued From page 3<br><br>Weekend Shifts are as follows:<br><br>Day shift: 9:00 AM to 9:00 PM<br>Overnight: 9:00 PM to 9:00 AM<br><br>Review of the available fire drill records dated from March 6, 2006, to June 4, 2007 on June 25, 2007 at approximately 9:45 AM revealed that fire drills were not conducted on the day and night shift during the second quarter. Further review revealed that fire drills were not conducted on the night shift during the third quarter and fire drills were not conducted on the day shift during the fourth quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly. | I 135 | | |
| I 161 | 3507.2 POLICIES AND PROCEDURES<br><br>The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Review of the policy and procedure manual on June 26, 2007 at approximately 7:00 PM revealed no evidence of an annual review by the GHMRP's governing body. In an interview with the Qualified Mental Reatardation Professional (QMRP) it was acknowledged that the annual review by the GHMRP's governing body had not been done. | I 161 | The policy and procedure manual has been reviewed and approved by the governing body. Evidence of the review is on file in the policy and procedure manual. The policies and procedures will be reviewed by the governing body on an annual basis. | 7/20/07 |
| I 163 | 3507.4(a) POLICIES AND PROCEDURES<br><br>The manual shall incorporate policies and procedures for at least the following: | I 163 | | |

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| I 163 | Continued From page 4<br><br>(a) General administration, which covers the governing body, organization charts, internal assessment of the quality of care, and fiscal management;<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on staff interview and record review, the facility failed to develop and implement its established policies to ensure the health and safety for six of the six residents in the sample. (Resident #1,#2,#3,#4,#5 and #6)<br><br>The finding includes:<br><br>1. Cross refer to W153. The facility failed to develop a policy on reporting incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on June 25, 2007 at approximately 4:15PM revealed that the facility did not report incidents that posed a risk to client health or safety to the Department of Health (DOH). Review of the facility's "Incident Management Policy" on June 25, 2007 at approximately 4:25PM revealed that allegations of abuse, neglect and mistreatment are to be reported no later than eight hours to the DOH. There was no documented evidenced that the facility reported incidents that posed a risk to client health or safety to the DOH.<br><br>2. The facility failed to implement their policy on reporting incidents of neglect to governmental agencies, as required by DC regulation (22 | I 163 | The Program Director will revise and clarify the agency's Policies and Procedures to further address identification, classification and handling of incidents following regulatory guidelines. Incidents will be managed in accordance with DC regulation 22 DCMR Chapter 35 Section 3519.10. Staff will be re-trained on the incident reporting procedures. The incident alleging abuse and neglect for Client # 3 will be forwarded to DOH. | 7/31/07 |

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| I 163 | Continued From page 5<br>DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Interview with the House Manager on June 25, 2007 at approximately 4:20 PM revealed that the facility did report allegations of neglect no later than eight hours to the DOH. Review of an unusual incident report dated May 25, 2007 on June 25, 2007 at approximately 10:19AM revealed that Client #3 who had one to one staffing eloped from the facility on that date. There was no documented evidenced that the DOH was notified of the incident.<br><br>3. The facility failed to implement their policy on reporting incidents of abuse to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) as evidenced by:<br><br>Review of an unusual incident report dated March 2, 2007 on June 25, 2007 at approximately 10:19 AM revealed that Resident #3 was pushed by Direct Care Staff #1 after Resident #3 spat on the direct care staff. Interview with the House Manager on June 25, 2007 at approximately 10:20 AM revealed that Direct Care Staff #1 was immediately removed from duty and subsequently terminated her employment from the facility. Review of the facility's "Incident Management Policy" on June 25, 2007 at approximately 4:25PM revealed that allegations of abuse, neglect and mistreatment are to be reported no later than eight hours to the DOH. There was no documented evidence that this incident had been reported to governmental agencies as required. | I 163 | See page 5<br><br>Additionally, QMRP will ensure that all incidents reports are generated to all pertinent parties and investigated according to policy and procedure. | 7/31/07 |
| I 208 | 3509.6 PERSONNEL POLICIES<br><br>Each employee, prior to employment and | I 208 | | |

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| I 206 | Continued From page 6<br>annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.<br><br>This Statute Is not met as evidenced by:<br>Surveyor: 19078<br>Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file.<br><br>The finding includes:<br><br>Review of personnel records on June 26, 2007 at approximately 4:59 PM revealed no documented evidence of current health certificates for two direct staff members, two LPN's, one RN, Primary Care Physician, Psychologist, Social Worker and Physical Therapist consultants. In an interview with the House Manager on June 26, 2007 at approximately 5:10PM it was acknowledged that the health certifications were not available during the survey. | I 206 | The health certificates for all staff and consultants have been obtained. Program Director/Human Resources will ensure that all health certifications are updated annually for each staff consultant and maintained in the personnel records.<br>Staff/consultants will be notified of the need to submit a current health certificate within 60-days of the current one's expiration. | 7/20/07-ongoing |
| I 227 | 3510.5(d) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(c) Infection control for staff and residents;<br><br>This Statute Is not met as evidenced by:<br>Surveyor: 19078<br>Based on observation, staff interview and record review, the facility failed to effectively train staff to | I 227 | | |

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| I 227 | Continued From page 7<br>implement emergency measures for six of six residents in the facility. (Resident #1, #2, #3, #4, 5 and 6 )<br><br>The findings include:<br><br>1. Interview with the House Manager on June 26, 2007 at approximately 4:58 PM revealed that all staff was not trained in CPR. Record review on June 26, 2007 at approximately 4:59 PM revealed that two out of eleven staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.<br><br>2. Interview with the House Manager on June 26, 2007 at approximately 4:56 PM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 4:57 PM revealed that three out of eleven staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. | I 227 | All staff lacking training in CPR will receive training.<br><br>All staff lacking training in First Aid will receive training.<br><br>The QMRP and House Manager will review staff training needs on a monthly basis and register staff for training within 60-days of the expiration dates of current training. A schedule of upcoming training will continue to be posted in each facility. | 7/31/07-Ongoing |
| I 261 | 3512.2 RECORDKEEPING: GENERAL PROVISIONS<br><br>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19075 | I 261 | The health certificates for all staff and consultants have been obtained. Program Director/Human Resources will ensure that all health certifications are updated annually for each staff consultant and maintained in the personnel records.<br>Staff/consultants will be notified of the need to submit a current health certificate within 60-days of the current one's expiration. | |
| I 379 | 3519.10 EMERGENCIES<br><br>In addition to the reporting requirement in 3519.5, | I 379 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G174 | A. BUILDING _____ B. WING _____ | 06/26/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SYMBRAL | 4422 20TH STREET, NE WASHINGTON, DC 20011 |

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| I 379 | Continued From page 8<br>each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10).<br><br>The findings include:<br><br>1. Review of an unusual incident report dated June 20, 2007 on June 26, 2007 at approximately 10:15 AM revealed that Resident #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:16 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>2. Review of an unusual incident report dated May 25, 2007 on June 25, 2007 at approximately 10:17AM revealed that Resident #3 who had one to one staffing eloped from the facilty on that date. Interview with the House Manager on June 25, 2007 at approximately 4:20 PM revealed that | I 379 | The Program Director will revise and clarify the agency's Policies and Procedures to further address identification, classification and handling of incidents following regulatory guidelines. Incidents will be managed in accordance with DC regulation 22 DCMR Chapter 35 Section 3519.10. Staff will be re-trained on the incident reporting procedures. The incident alleging abuse and neglect for Client # 3 will be forwarded to DOH. | 7/31/07 |

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| I 379 | Continued From page 9<br><br>Direct Care Staff #2 was placed on administrative leave. Review of a progress note dated May 25, 2007 on June 26, 2007 at approximately 3:00PM revealed that when Resident #3 returned to the facility on May 25, 2007, his left knee and ankle was swollen. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>[Note: Review of a progress note dated May 25, 2007 on June 26, 2007 at approximately 3:00PM revealed that when Resident #3 returned to the facility on May 25, 2007, with a swollen left knee . Review of a radiology report of the right/left knees dated June 4, 2007 on June 26, 2007 at approximately revealed that the Client #3 had not sustained any fractures to the knees]<br><br>3. Review of an unusual incident report dated May 30, 2007 on June 26, 2007 at approximately 5:22 PM revealed that while at the day program Resident #1 was discovered to have a "purple bruise on his left pinky and ring finger". Further review revealed that Client #1 was sent to the emerency room and was treated and released with a finger splint. Interview with the House Manager on June 25, 2007 at approximately 5:23 PM revealed that the incident had been forwarded to the facility's Incident management coordinator. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>4. Review of an unusual incident report dated May 1, 2007 on June 25, 2007 at approximately 10:17 AM revealed that Resident #6 sustained cuts on the fingers of the left hand. Interview with the House Manager on June 25, 2007 at approximately 10:18 AM revealed she was aware of the incident and that the facility's incident | I 379 | See page 9 | |

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| I 379 | Continued From page 10<br><br>manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>5. Review of an unusual incident report dated April 24, 2007 on June 25, 2007 at approximately 10:19 AM revealed that Resident #6 fell half-way down some stairs and than hit his left hand on the doors plate glass which broke and he was sent to the emerency room. Further review revealed that the client was treated and released without sutures. Interview with the House Manager on June 25, 2007 at approximately 10:20 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>6. Review of an unusual incident report dated March 2, 2007 on June 25, 2007 at approximately 10:22 AM revealed that Resident #3 was pushed by Direct Care Staff #1 after the client spit on the direct care staff. Interview with the House Manager on June 25, 2007 at approximately 10:23 AM revealed that Direct Care Staff #1 was immediately removed from duty and subsequently terminated her employment from the facility. There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>7. Review of an unusual incident report dated June 29, 2006 on June 26, 2007 at approximately 10:24 AM revealed that Resident #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:25 AM revealed she | I 379 | See page 9 | |

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| I 379 | Continued From page 11<br><br>was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>8. Review of an unusual incident report dated August 23, 2006 on June 25, 2007 at approximately 10:26 AM revealed that Resident #2 fell and sustained a laceration on his forehead and was transported via 911 to the emerency room and treated with nine sutures and released. Interview with the House Manager on June 25, 2007 at approximately 10:27 AM revealed she was aware of the incident and that the facility's incident management coordinator had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.<br><br>9. Review of an unusual incident report dated May 13, 2006 on June 25, 2007 at approximately 10:28AM revealed that Resident #4 had eloped from the facility on that date at 2:00PM and was found by the D.C. Metropolitan Police. Interview with the House Manager on June 25, 2007 at approximately 10:30 AM revealed that she was aware of the incident and that the facility's incident managment coordinator had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required. | I 379 | See page 9<br><br>Additionally, QMRP/Incident Management Coordinator will ensure that all incidents reports are investigated as applicable and generated to all pertinent parties and investigated according to policy and procedure. | |
| I 391 | 3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Each GHMRP shall have available qualified professional staff to carry out and monitor | I 391 | | |

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| I 391 | Continued From page 12<br><br>necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:<br><br>(a) Medicine;<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on observation, staff interview, and record review failed to provide preventive and general care for two of three residents in the sample. (Resident #1and Resident #3)<br><br>The findings include:<br><br>1. The facility's medical services failed to ensure that Resident #1's psychotropic reviews were in the medical record as evidenced by:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 6:15 PM, revealed Resident #1 received Loxapine 50mg and Depakote 750 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:16 PM revealed that the medication was prescribed for behavior management. Review of Resident #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Resident #1 has an Axis I diagnosis of Autism. Review of Resident #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that there were no psychotropic | I 391 | The Designated Nurse has followed up with the psychiatrist to obtain the reviews from the psychotropic meetings held in April and May 2007 for client's #1 and #3. Nurse will ensure that the Psychotropic review forms are obtained and filed in the client's records within 24 hours following the medication review. | 7/16/07 |

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| I 391 | Continued From page 13<br><br>reviews for April and May 2007. In an interview with the House Manager on June 26, 2007 at approximately 1:30 PM it was acknowledged that Resident #1 did not have psychotropic reviews for April and May 2007<br><br>2. The facility's medical services failed to ensure that Resident #3's psychotropic reviews were in the medical record as evidenced by:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 5:55 PM, revealed Resident #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:05 PM revealed that the medication was prescribed for behavior management. Review of Resident #3's Psychiatric Assessment dated February 8, 2007 on June 26, 2007 at approximately 3:30 PM revealed that Resident #3 has an Axis I diagnosis of Chronic Undifferentiated Schizophrenia. Review of Client #3's medical record on June 26, 2007 at approximately 3:35 PM revealed that there were no psychotropic reviews for April and May 2007. In an interview with the House Manager on June 26, 2007 at approximately 4:40 PM it was acknowledged that Resident #3 did not have psychotropic reviews for April and May 2007. | I 391 | See page 13 | |
| I 395 | 3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The | I 395 | | |

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| I 395 | Continued From page 14<br><br>professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:<br><br>(e) Nursing;<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19078<br>Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of three residents in the sample. (Resident# 3)<br><br>The findings include:<br><br>1. The facility's nursing services failed to ensure that the results of Resident #3's EEG studies were obtained as evidenced by:<br><br>Review of an EEG consult dated September 26, 2006 on June 20, 2007 at approximately 4:05PM revealed that Resident #3 had an EEG performed on that date and that the facility could call for the results. Interview with LPN on June 26, 2007 at approximately 4:06 PM revealed Resident #3's EEG results were not obtained. There was no documented evidence that the results of the EEG results were obtained by the facility.<br><br>2. Cross refer to W371.2. The facility's nursing services failed to ensure that Resident #3 participated in a self-medication program. | I 395 | The EEG results have been obtained and filed for Client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of laboratory studies are obtained and filed in the client records.<br><br>The Designated/Medication Nurse will ensure that Client #3 is encouraged, to participate in his medication administration to the extent of which assessed capable. | 7/16/07<br><br>7/16/07 |
| I 436 | 3521.7(f) HABILITATION AND TRAINING<br><br>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: | I 436 | | |

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| I 436 | Continued From page 15<br><br>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on observations, staff interview and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for one of three residents in the sample. (Resident #3)<br><br>The finding includes:<br><br>During the observation of the evening medication pass, on June 25, 2007 at approximately 5:55 PM, Resident #3 was administered Risperdal 1.5 mg and Trazadone 150 mg by mouth by the LPN. Resident #3 was observed to bring a cup of water to the table when he came to receive his medication. Further observation revealed that Resident #3 was able to independently hold his medicationcup and cup of water and consume thre contents with-out spillage. Resident#3 was observed to pour Lactolose 30 ml in a cup, mix water in the cup and stir the contents with a spoon before consuming the medication. Interview with the LPN on June 25, 2007 at approximately 5:57PM revealed that Resident #3 had a self-medication assessment but did not have a self-medication program. Review of the self-medication assessment dated February 2, 2007 on June 26, 2007 at approximately 4:11PM Indicated that Resident # 3 was recommended " monitor level of participation medication administration in the next 90 days. Review of the Individual Support Plan (ISP) dated February 2, | I 436 | Cross reference response to L395-3520.2 #2. | |

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| I 436 | Continued From page 16<br>2007 recommended that Resident #3 "learn self-medication". There was no evidence that the client was given the opportunity to participate in a self- medication program. | I 436 | | |
| I 500 | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Surveyor: 19076<br>Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of two residents in the sample. (Resident #3 )<br><br>The finding includes:<br><br>Observation of the evening medication administration on June 25, 2007 at approximately 5:55 PM, revealed Resident #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 6:05 PM revealed that the medication was prescribed for behavior management. Review of the Resident #3' s physicians orders dated June 1, 2007 on June 26, 2007 at approximately 3:50 PM revealed that Risperdal 1.5 mg and Trazadone 150 mg by mouth twice a day was incorporated in a Behavior Support Plan (BSP) dated February 21, 2007, to | I 500 | Assessment for legal guardianship will be completed for client #3 and pursuance for guardianship will occur based on the assessed needs of Clients #3.<br><br>Additionally, QMRP will continue to ensure that family members are fully knowledgeable and understand the rights of the clients. QMRP will also ensure documentation of information regarding all efforts to involve family members in the decision making process as well as ongoing measures (i.e., Human Rights Committee Reviews to discuss risk –vs- benefits) to ensure protection of their rights. | 7/31/07-Ongoing |

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| I 500 | Continued From page 17<br>address behaviors associated with elopement and physical aggression. Interview with the House Manager on June 26, 2007 at approximately 3:55 PM revealed that Resident #3 did not have a legal guardian or surrogate decision maker. The review of Resident #3's Psychological Assessment dated February 4, 2007 on June 26, 2007 at approximately 4:55 PM indicated that he does not evidence the capacity to make independent decisions on he behalf regarding his habilitation planning, placement, treatment, financial and medical matters and can not give informed consent. There was no documented evidence that the facility informed Resident #3 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. | I 500 | QMRP will continue to pursue securing legal advocacy, as well as, guardianship resources through the quality trust, courts and other applicable services, based on the individual needs for each client. Documentation of these ongoing efforts will be maintained in the client records.<br><br>Client #3's psychotropic medication regimen will continue to be evaluated monthly by the psychiatrist and psychiatric evaluations reviewed and updated per individual assessment and need. | 7/31/07-Ongoing |